HARDSHIP CONSIDERATIONS

Instructions
To be completed by the Community Mental Health Center and/or Alcohol and Drug Provider. All "yes" answers must include a detailed explanation.

Personal Information *(Please Print)* CID #: _____

Consumer Name: _____
(First) *(MI)* *(Last)*

Address: _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

Check type of service(s):): ☐ III.7 Inpatient Treatment ☐ II.5 Day Treatment ☐ II.1 Intensive Outpatient Treatment
☐ II.1 & III.1 Slip Slot ☐ Assessments ☐ Ind/Group Counseling ☐CARE ☐SED☐ IMPACT ☐ MH Outpatient ☐MH/CD

☐ **YES** ☐ **NO** ☐ **N/A** For CARE services, will mental health services exceed two or more units per month? If yes, please indicate the number of units per month and the duration for which this level of services will continue.

_____

_____

☐ **YES** ☐ **NO** ☐ **N/A** For SED services, will mental health services exceed eight or more units per month? If yes, please indicate the number of units per month and the duration for which this level of services will continue.

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☐ **YES** ☐ **NO** Is there an imminent risk of hospitalization, residential placement, or out of home placement? Or is there potential for involvement/increased involvement with other systems (e.g., law enforcement, CPS, UJS, DOC)? If yes, please describe.

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☐ **YES** ☐ **NO** Is there an emergency situation (e.g., consumer is suicidal, acutely psychotic, demonstrates potential relapse, or has a dual diagnosis) that can be treated in a community setting? If yes, please describe.

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I hereby attest that this information is true and correct.

_____

Signature (CMHC or Alcohol & Drug Provider Representative) Date